Department of Health and Human Services

Centers for Medicare & Medicaid Services

Center for Program Integrity

Illinois Focused Program Integrity Review

Medicaid Managed Care Oversight

July 2024

Final Report

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I. Executive Summary

Objectives

The Centers for Medicare & Medicaid Services' (CMS) conducted a focused program integrity to assess Illinois' program integrity oversight efforts of its Medicaid managed care for the Fiscal Years (FY) 2020 – 2022. This focused review specifically assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. A secondary objective of this review was to provide the state with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid managed care.

To meet the objectives of this focused review, CMS reviewed information and documents provided in response to the CMS managed care review tool provided at the initiation of the review. CMS also conducted in-depth interviews with the State Medicaid agency (SMA) and evaluated program integrity activities performed by selected managed care organizations (MCOs) under contract with the state Medicaid agency.

This report includes CMS' findings and resulting recommendations, as well as observations, which were identified during the focused review.

Findings and Recommendations

Findings represent areas of non-compliance with federal and/or state Medicaid statutory, regulatory, sub-regulatory, or contractual requirements. CMS identified one finding that creates risk to the Illinois Medicaid program related to managed care program integrity oversight. In response to the finding, CMS identified **one** recommendation that will enable the state to come into compliance with federal and/or state Medicaid requirements related to managed care program integrity oversight. This recommendation includes the following:

MCO Contract Requirements

> **Recommendation #1:** To come into compliance with § 438.608(d)(1)(i), Illinois should revise the MCO general contract to include language specifying whether the MCO may retain all overpayments recovered due to fraud, waste, or abuse, or if there are extenuating circumstances wherein the state may retain overpayments.

Observations

Observations represent operational or policy suggestions that may be useful to the state in the oversight of its Medicaid managed care program. CMS identified **four** observations related to Illinois's managed care program integrity oversight. While observations do not represent areas of non-compliance with federal and/or state requirements, observations identify areas that may pose a vulnerability or could be improved by the implementation of leading practices. The observations identified during this review include the following:

MCO Investigations of fraud, waste, and abuse

Observation #1: CMS encourages Illinois to work with the MCOs to improve the quality and quantity of case referrals through routinely provided program integrity training and frequent feedback to the MCOs regarding their case referral performance. CMS also encourages Illinois to establish metrics to uniformly assess the quality and quantity of case referrals.

Observation #2: CMS encourages Illinois to review the overpayment procedures of its MCOs and ensure the MCOs make recovering overpayments a prioritized program integrity contract requirement.

Observation #3: CMS encourages Illinois to ensure that MCOs have sufficient corrective action plan procedures in place per MCO general contract requirements and utilize them appropriately to address non-compliant Medicaid providers.

Observations #4: CMS encourages Illinois to include contract language addressing conducting investigative provider site visits to ensure that all MCOs are utilizing this practice.

II. Background

Focused Program Integrity Reviews

In the Comprehensive Medicaid Integrity Plan for Fiscal Years (FYs) 2019-2023, CMS set forth its strategy to safeguard the integrity of the Medicaid program.[1] This plan encompasses efforts to ensure that states are adhering to key program integrity principles, including the requirement that state Medicaid programs have effective oversight and monitoring strategies that meet federal standards.

As a part of these efforts, CMS conducts focused program integrity reviews on high-risk areas in the Medicaid program, such as managed care, new statutory and regulatory provisions, non-emergency medical transportation, telehealth, and personal care services. These reviews include onsite or virtual state visits to assess the effectiveness of each state's program integrity oversight functions and identify areas of regulatory non-compliance and program vulnerabilities. Through these reviews, CMS also provides states with feedback, technical assistance, and educational resources that may be used to enhance program integrity in Medicaid.

Medicaid Managed Care

Medicaid managed care is a health care delivery system organized to manage cost, utilization, and quality. Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care. This approach provides for the delivery of Medicaid

[1] https://www.cms.gov/files/document/comprehensive-medicaid-integrity-plan-fys-2019-2023.pdf

health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that receive a set per member per month (capitation) payment for these services. By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.

Overview of the Illinois Managed Care Program and the Focused Program Integrity Review

The Illinois Department of Healthcare and Family Services (HFS) is the agency responsible for the administration of the Illinois Medicaid program, HealthChoice Illinois. Within HFS, the Office of Inspector General (OIG) is the organizational unit tasked with oversight of program integrity-related functions for the managed care program. During the review period, Illinois contracted with six MCOs to provide health services to the Medicaid population. As part of this review, three of these MCOs were interviewed: Blue Cross Community Health Plan of Illinois (BCCHP), Meridian Health Plan (Meridian), and Molina Healthcare of Illinois (Molina). Appendix C provides enrollment and expenditure data for each of the selected MCOs.

In March 2023, CMS conducted a focused program integrity review of Illinois's managed care program. This focused review assessed the state's compliance with CMS regulatory requirements at 42 CFR Part 438, Subpart H. As a part of this review, CMS also evaluated program integrity activities performed by selected MCOs under contract with the state Medicaid agency. CMS interviewed key staff and reviewed other primary data. CMS also evaluated the status of Illinois's previous corrective action plan that was developed in response to a previous Focused Program Integrity Review of Illinois's managed care program conducted by CMS in 2018, the results of which can be found in Appendix A.

During this review, CMS identified a total of one recommendation and four observations. CMS also included technical assistance and educational resources for the state, which can be found in Appendix B. The state's response to CMS' draft report can be found in Appendix D, and the final report reflects changes CMS made based on the state's response.

This review encompasses the following five areas:

A. **State Oversight of Managed Care Program Integrity Activities** - CMS established requirements at §§ 438.66 and 438.602 that require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas. These areas include, but are not limited to: data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.
B. **MCO Contract Compliance** - Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse, such as implementing compliance plans, payment suspensions based on credible allegations of fraud, and overpayment reporting.

C. **Interagency and MCO Program Integrity Coordination** - Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state Medicaid Fraud Control Unit (MFCU) play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars. Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA.

D. **MCO Investigations of Fraud, Waste, and Abuse** - Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state Program Integrity Unit (PIU) or any potential fraud directly to the state's MFCU. Similarly, as required by § 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

E. **Encounter Data** - In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every 3 years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO.

III. Results of the Review

A. State Oversight of Managed Care Program Integrity Activities

State oversight of managed care program integrity activities is critical to ensuring that MCOs are meeting all CMS requirements and state contractual requirements. CMS established state monitoring requirements at §§ 438.66 and 438.602 which require the SMA to have a monitoring system that includes mechanisms for the evaluation of MCO performance in several program integrity areas, including but not limited to; data, information, and documentation that must be submitted under §§ 438.604 – 606, as well as compliance with contractual program integrity requirements under §§ 438.608.

In Illinois, these oversight and monitoring requirements are met. Section 5.35.1.1 of the Illinois MCO general contract states that the MCO shall "…have a designated Special Investigations Unit (SIU) to oversee Fraud, Waste and Abuse investigations." The contract continues in Section 5.35.1.2, requiring the MCO to, "…employ Fraud, Waste, and Abuse Investigators at a minimum ratio of one (1) Investigator to every one-hundred thousand (100,000) Enrollees." However, during the review exit conference, HFS-OIG stated if the number of MCO investigators fell below the ratio (per contract requirements), they would be made aware of this only if the MCO communicated the decrease in staff.

CMS did not identify any findings or observations related to these requirements.

B. MCO Contract Compliance

Regulations at § 438.608 require the state, through its contracts with the MCOs, to ensure that MCOs implement and maintain arrangements or procedures that are designed to detect and prevent fraud, waste, and abuse. These requirements extend to any subcontractor that is delegated responsibility for coverage of services and payment of claims under the contract between the state and the MCO. As part of this review, the MCO general contract was evaluated for compliance with several of these requirements, which are described in greater detail below.

The MCO general contract for Illinois is developed by the Division of Medical Programs Bureau of Managed Care and Bureau of Quality Management. HFS-OIG monitors contract compliance with the fraud, waste, and abuse requirements.

Compliance Plans

In accordance with §§ 438.608(a)(1)(i)-(vii), states must require MCOs to implement compliance programs that meet certain minimal standards, which include the following:

1. Written policies, procedures, and standards of conduct that articulate the MCO's commitment to comply with all applicable requirements and standards under the contract, and all applicable Federal and state requirements
2. Designation of a Compliance Officer who is responsible for developing and implementing policies, procedures, and practices designed to ensure compliance with the requirements of the contract and who reports directly to the Chief Executive Officer and the board of directors
3. Establishment of a Regulatory Compliance Committee on the Board of Directors and at the senior management level charged with overseeing the MCO's compliance program and its compliance with the requirements under the contract
4. A system for training and education for the Compliance Officer, the organization's senior management, and the organization's employees for the Federal and State standards and requirements under the contract
5. Effective lines of communication between the compliance officer and employees
6. Enforcement of standards through well-publicized disciplinary guidelines
7. Establishment and implementation of procedures and a system with dedicated staff for routine internal monitoring and auditing of compliance risks, prompt response to compliance issues as they are raised, investigation of potential compliance problems as identified in the course of self-evaluation and audits, correction of such problems promptly and thoroughly (or coordination of suspected criminal acts with law enforcement agencies) to reduce the potential for recurrence, and ongoing compliance with the requirements under the contract

Section 5.35.1.1 through 5.35.1.8 of Illinois's MCO general contract explicitly addresses the requirement that all seven compliance plan elements listed above be addressed. A review of the MCOs' compliance plans and programs found that each MCOs compliance plan contained the required elements in accordance with §§ 438.608(a)(1)(i)-(vii).

CMS did not identify any findings or observations related to these requirements.

Beneficiary Verification of Services

In accordance with § 438.608(a)(5), the state, through its contract with the MCO, must require a method to verify, by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and the application of such verification processes on a regular basis.

In Illinois, this requirement is met. MCO contract Section 5.35.6 requires that MCOs maintain a program for beneficiary verification. The MCO plan verifying whether services billed by providers were received is submitted to the SMA for approval.

CMS did not identify any findings or observations related to these requirements.

False Claims Act Information

In accordance with § 438.608(a)(6), the state, through its contract with the MCO, must require that, in the case of MCOs that make or receive annual payments under the contract of at least $5,000,000, there are written policies for all employees of the entity, and of any contractor or agent, that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Social Security Act (the Act), including information about rights of employees to be protected as whistleblowers.

The state is compliant with this requirement. A review of the state's policy found that HFS-OIG has written policies for Illinois Medicaid employees, contractors, MCOs, and agents that provide detailed information about the False Claims Act and other Federal and State laws described in section 1902(a)(68) of the Act, including information about rights of employees to be protected as whistleblowers.

CMS did not identify any findings or observations related to these requirements.

Payment Suspensions Based on Credible Allegations of Fraud

Pursuant to § 438.608(a)(8), states must ensure that MCOs suspend payments to a network provider for which the state determines there is a credible allegation of fraud in accordance with § 455.23.

Illinois Medicaid MCOs are contractually-required to suspend payments to providers at the state's request. The MCO contract requires the MCOs to suspend providers once the state has determined a payment suspension should be imposed and no exception applies. Section 5.35.13.11 states that the "Contractor shall have policies and procedures to implement suspension of payments to a Network Provider for which the OIG determines there is a credible allegation of Fraud in accordance with 42 CFR 455.23."

CMS did not identify any findings or observations related to these requirements.

Overpayments

Regulations at §§ 438.608(a)(2) and (d) require states to maintain oversight of MCOs' overpayment recoveries. Specifically, § 438.608(a)(2) requires states to ensure that MCOs promptly report all overpayments identified or recovered, specifying the overpayments due to potential fraud, to the state. In addition, § 438.608(d) requires states to specify in MCOs' contracts how the MCOs should treat overpayment recoveries. This must include retention policies for recoveries of all overpayments, including overpayments due to fraud, waste, and abuse; the process, timeframes, and documentation requirements for reporting the recovery of all overpayments; and the process, timeframes, and documentation requirements for payment of recoveries to the state in situations where the MCO is not permitted to retain some or all of the recoveries. States must also ensure that MCOs have a process for network providers to report to the MCO when they have received an overpayment (including the reason for the overpayment), and to return the overpayment to the MCO within 60 calendar days. Each MCO must report annually to the state on their recoveries of overpayments, and the state must use the results of the information in setting actuarially sound capitation rates, consistent with the requirements in § 438.4.

The state adequately addressed most of the requirements at §§ 438.608(a)(2) and (d) in the MCO general contract. Section 5.35.3 from Amendment 2 of the Illinois contract states, "Contractor shall have a provision for prompt reporting of all overpayments identified or recovered, specifying the overpayments due to potential Fraud, to the OIG." Additionally, Section 5.35.11 of the MCO general contract requires that the MCO have internal policies and procedures to identify and recover overpayments within timeframes determined by the OIG, specifically for the recovery of overpayments due to fraud, waste, and abuse. All overpayments must be reported to the OIG at the claim and service level on a quarterly basis. **However, there were no contractual provisions outlining the retention policies for the treatment of recoveries of overpayments from the MCO to a provider, as required by § 438.608(d)(1)(i).**

> **Recommendation #1:** To come into compliance with § 438.608(d)(1)(i), Illinois should revise the MCO general contract to include language specifying whether the MCO may retain all overpayments recovered due to fraud, waste, or abuse, or if there are extenuating circumstances wherein the state may retain overpayments.

C. Interagency and MCO Program Integrity Coordination

Within a Medicaid managed care delivery system, MCO SIUs, the SMA, and the state MFCU play important roles in facilitating efforts to prevent, detect, and reduce fraud and abuse to safeguard taxpayer dollars and beneficiaries. Each of these entities performs unique functions that are critical to providing effective oversight of the Medicaid program. The ability to reduce fraud in Medicaid managed care will be greatly enhanced as these entities develop methods and strategies to coordinate efforts. Ineffective collaboration can adversely affect oversight efforts, putting taxpayer dollars and beneficiaries at risk.

Under § 455.21, the SMA is required to cooperate with the state MFCU by entering into a written agreement with the MFCU. The agreement must provide a process for the referral of suspected provider fraud to the MFCU and establish certain parameters for the relationship between the MFCU and the SMA. Illinois has a Memorandum of Understanding (MOU) in place with the MFCU that meets the regulatory criteria. Specifically, there is a MOU that contains procedures by which the MFCU will receive referrals of potential fraud from MCOs, as required by 455.21(c)(3)(iv). Additionally, the state meets with the MFCU regularly to discuss case referrals.

While there is no requirement for SMAs to meet on a regular basis with its MCOs for collaborative sessions to discuss pertinent program integrity issues regarding fraud, waste, and abuse and relevant contractual concerns, such collaborative sessions are an effective and important process to ensure open communication and strong partnerships. The SMA does hold monthly collaborative sessions with its MCOs to discuss program integrity issues, such as case referrals, leads, and administrative actions. The HFS-OIG has developed monthly meetings with each MCO, and in conjunction with the MFCU, conducts annual educational training sessions for each MCO.

CMS did not identify any findings or observations related to these requirements.

D. MCO Investigations of Fraud, Waste, and Abuse

State Oversight of MCOs

Regulations at § 438.608(a)(7) require states to ensure that MCOs promptly refer any potential fraud, waste, and abuse that the MCO identifies to the state PIU or any potential fraud directly to the state's MFCU. Similarly, as required by §§ 455.13-17, states must have an established process for the identification, investigation, referral, and reporting of suspected fraud, waste, and abuse by providers and MCOs.

Illinois has such a process in accordance with §§ 455.13-17 and § 438.608(a)(7). Illinois requires, in section 5.35.13.4 Amendment 2 of the Illinois contract, that "Contractor [MCO] shall report, as specified by OIG, all suspected Fraud, Waste, Abuse, mismanagement, and misconduct as follows:

> 5.35.13.4.1 Within three (3) Business Days, all alleged criminal conduct;
> 5.35.13.4.2 Monthly, any program integrity case opened within the previous month;
> 5.35.13.4.3 Quarterly, reports as defined under the Reporting Tool Guidelines…".

Section 5.35.1.8 of the MCO general contract further supports this, stating that within their quarterly reporting, the MCOs are required to submit, "…all instances of suspected Fraud, Waste, Abuse, and financial misconduct, and certify that the report contains all such instances or that there was no suspected Fraud, Waste, Abuse, or misconduct during that quarter."

The HFS-OIG has educated the MCOs regarding the definition of fraud, waste, and abuse. In addition, HFS-OIG meets monthly with the MCOs regarding investigations.

However, CMS observed a lack of quantity and quality case referrals from the MCO SIUs. During the interview with the MFCU, CMS noted that there was a decrease in the quality and quantity of fraud referrals for the review period. To address this concern, Illinois could provide program integrity training and frequent feedback to MCOs regarding their case referral performance, as well as establish metrics to uniformly assess their case referrals.

> **Observation #1**: CMS encourages Illinois to work with the MCOs to improve the quality and quantity of case referrals through routinely provided program integrity training and frequent feedback to the MCOs regarding their case referral performance. CMS also encourages Illinois to establish metrics to uniformly assess the quality and quantity of case referrals.

MCO Oversight of Network Providers

CMS verified whether each Illinois MCO had an established process for conducting investigations and making referrals to the state, consistent with CMS requirements and the state's contract requirements.

Overall, CMS found the reported MCO processes for the investigation of suspected fraud, waste, and abuse to meet CMS requirements and state contract requirements. Illinois' MCO general contract requires that each MCO have an established process to monitor its providers for non-compliance with contractual agreements and medical governance standards. A promising practice for MCOs to maintain such oversight is to implement corrective action plans for its network providers found to be non-compliant. CMS found that BCCHP and Molina did utilize corrective action plans; however, Meridian did not utilize corrective action plans during the review period. However, Meridian has a Physician Advisory Committee who makes the determination if a provider is placed on a corrective action plan. In addition, the MCO general contract does not address investigative unannounced provider site visits. The MCOs did not perform any investigative provider site visits during the review period. Investigative provider site visits are an effective tool in the detection of fraud, waste, and abuse within the Medicaid program.

All three MCOs reported use of an internal or contracted SIU tasked with identifying and conducting investigations of potential fraud, waste, and abuse. Indicators of potential issues were identified through different sources, including but not limited to claims, hotline calls, referrals from subcontractors, referrals from HFS-OIG, HFS-OIG algorithms, and data mining. Upon receipt of a case referral from any of these sources, a preliminary investigation is conducted to determine if a case should be opened by the SIU. When a case is opened following the preliminary investigation, a referral is sent to the state and a full investigation is conducted.

Figure 1 below describes the number of investigations referred to Illinois by each MCO.

Figure 1. Number of Investigations Referred to Illinois by each MCO

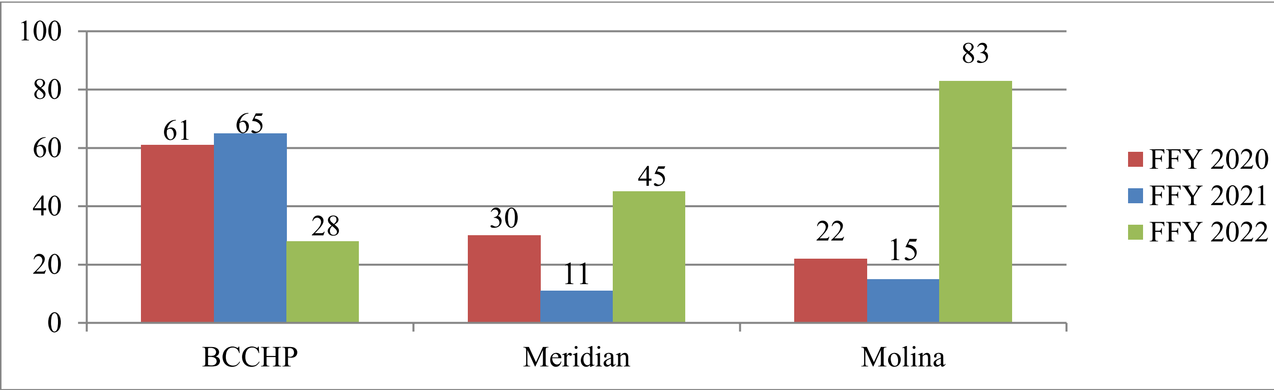

Table 1, below, describes each MCO's recoveries from program integrity activities. The state must obtain a clear accounting of any recoupments for these dollars to be accounted for in the annual rate-setting process (§ 438.608(d)(4)). Without these adjustments, MCOs could be receiving inflated rates per member per month.

As illustrated below, the overpayments identified and recovered varies widely across MCOs. The number of overpayments identified and recovered by the MCOs is low for a managed care program of this size. The state reported Meridian had a large overpayment identified in FY22, as well as a lag between when the overpayments were identified and recovered due to their program integrity process during the review period. During the review, the state also noted that the MCOs have highlighted their cost avoidance efforts during discussions but could not confirm if the low number of overpayments was due directly to cost avoidance activities. To maintain effective oversight of overpayment identification, reporting, and recoveries by MCOs, it is advisable that states obtain evidence from MCOs in support of any MCO statements attributing a decline in the overpayments identified, reported, and recovered to cost avoidance activities or proactive measures, such as prepayment review.

Table 1: MCO Recoveries from Program Integrity Activities

BCCHP's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	126	56	$348,559.47	$267,898.12
2021	194	118	$269,723.38	$99,569.35
2022	174	75	$211,728.50	$97,258.10

Meridian's Recoveries from Program Integrity Activities

FY	Preliminary Investigations*	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	-0-	62	$289,214.66	$201,348.92
2021	-0-	52	$960,921.12	$26,629.72
2022	-0-	234	$9,169,901.44	$58,456.89

Meridian did not differentiate between preliminary and full investigations when a case is referred.

Molina's Recoveries from Program Integrity Activities

FY	Preliminary Investigations	Full Investigations	Total Overpayments Identified	Total Overpayments Recovered
2020	92	71	$583,793	$138,269
2021	155	132	$40,397	$40,209
2022	166	125	$720,519	$50,263

Observation #2: CMS encourages Illinois to review the overpayment procedures of its MCOs and ensure the MCOs make recovering overpayments a prioritized program integrity contract requirement.

Observation #3: CMS encourages Illinois to ensure that MCOs have sufficient corrective action plan procedures in place per MCO general contract requirements and utilize them appropriately to address non-compliant Medicaid providers.

Observations #4: CMS encourages Illinois to include contract language addressing conducting investigative provider site visits to ensure that all MCOs are utilizing this practice.

E. Encounter Data

In accordance with § 438.242, the state must ensure, through its contracts, that each MCO maintains a health information system that collects, analyzes, integrates, and reports encounter data. Additionally, § 438.242 further states that MCO contracts must specify the frequency and level of detail of beneficiary encounter data, including allowed amount and paid amount, that the state is required to report to CMS under § 438.818. The systems must provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Through a review of the Illinois MCO general contract and interviews with each of the MCOs, CMS determined that Illinois was in compliance with § 438.242. Specifically, the contract language states the MCOs must have a system(s) that will provide information on areas including, but not limited to, utilization, claims, grievances, appeals, and disenrollment for other

loss of Medicaid eligibility.

In addition, in accordance with § 438.602(e), the state must periodically, but no less frequently than once every three years, conduct, or contract for the conduct of, an independent audit of the accuracy, truthfulness, and completeness of the encounter data submitted by, or on behalf of, each MCO. Illinois was in compliance with § 438.602(e). Specifically, the Encounter Data Verification (EDV) Audit of the MCOs is completed every three years. The first EDV audit had an estimated completion date of July 17, 2023.

In addition, while it is not a requirement, regularly analyzing the encounter data submitted by MCOs will allow the state to conduct additional program integrity activities, such as identifying outlier billing patterns, payments for non-covered services, and fraudulent billing. Illinois has a process to regularly analyze MCO encounter data for program integrity purposes. Specifically, contract section 7.16.6 states MCOs must, "… submit complete and accurate data quarterly to the Department." The SMA confirmed that MCOs are required to submit claims level data to HFS-OIG. The HFS-OIG uses this data to conduct in-depth descriptive medical statistical analysis, outlier models, profiling, neural network techniques, and predictive modeling to perform dynamic and static data mining tasks at various levels. Furthermore, HFS-OIG analyzes claims data utilizing various algorithms based on fraud, waste and abuse models suggested by internal and external subject matter experts, CMS program toolkits, and case study algorithms.

CMS did not identify any findings or observations related to these requirements.

IV. Conclusion

CMS supports Illinois's efforts and encourages the state to look for additional opportunities to improve overall program integrity. CMS' focused review identified one recommendation and four observations that require the state's attention.

We require the state to provide a corrective action plan for the recommendation within 30 calendar days from the date of issuance of the final report. The corrective action plan should explain how the state will ensure that the recommendation has been addressed and will not reoccur. The corrective action plan should include the timeframes for each corrective action along with the specific steps the state expects will take place and identify which area of the SMA is responsible for correcting the issue. We are also requesting that the state provide any supporting documentation associated with the corrective action plan, such as new or revised policies and procedures, updated contracts, or revised provider applications and agreements. The state should provide an explanation if corrective action in any of the risk areas will take more than 90 calendar days from the date of issuance of the final report. If the state has already acted to correct compliance deficiencies or vulnerabilities, the corrective action plan should identify those corrections as well.

The state is not required to develop a corrective action plan for any observations included in this report. However, CMS encourages the state to take the observations into account when

evaluating its program integrity operations going forward.

CMS looks forward to working with Illinois to build an effective and strengthened program integrity function.

V. Appendices

Appendix A: Status of Prior Review

Illinois's last CMS program integrity review was in August 2018, and the report for that review was issued in January 2019. The report contained ten recommendations. During the virtual review in March 2023, CMS conducted a thorough review of the corrective actions taken by Illinois to address all recommendations reported in calendar year 2018. Nine recommendations were corrected and only one recommendation was partially corrected as identified below:

Findings

1. ***Given the limited number of provider investigations and referrals by the MCOs along with the low number of overpayments and terminations that the MCOs reported, ensure that MCOs are allocating sufficient resources to the prevention, detection, investigation, and referral of suspected provider fraud.***
   Status at time of the review: Partially Corrected

Appendix B: Technical Resources

To assist the state in strengthening its program integrity operations, CMS offers the following technical assistance and educational resources for the SMA.

- Access COVID-19 Program Integrity educational materials at the following links:
    - Risk Assessment Tool Webinar (PDF) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-tool-webinar.pdf
    - Risk Assessment Template (DOCX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.docx
    - Risk Assessment Template (XLSX) July 2021: https://www.medicaid.gov/state-resource-center/downloads/risk-assessment-template.xlsx
- Access the Resources for State Medicaid Agencies website at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Program/Education/Resources-for-SMAs to address techniques for collaborating with MFCUs.
- Access the Medicaid Payment Suspension Toolkit at https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/FraudAbuseforProfs/Downloads/medicaid-paymentsuspension-toolkit-0914.pdf, to address overpayment and recoveries.
- Use the program integrity review guides posted in the Regional Information Sharing Systems (RISS) as a self-assessment tool to help strengthen the state's program integrity efforts. Access the managed care folders in the RISS for information provided by other states including best practices and managed care contracts. http://www.riss.net/
- Continue to take advantage of courses and trainings at the Medicaid Integrity Institute. More information can be found at https://www.cms.gov/medicaid-integrity-institute
- Regularly attend the Fraud, Waste, and Abuse Technical Advisory Group and the Regional Program Integrity Directors calls to hear other states' ideas for successfully managing program integrity activities.
- Participate in Healthcare Fraud Prevention Partnership studies and information-sharing activities. More information can be found at https://www.cms.gov/hfpp.
- Consult with other states that have Medicaid managed care programs regarding the development of policies and procedures that provide for effective program integrity oversight, models of appropriate program integrity contract language, and training of managed care staff in program integrity issues. Use the Medicaid PI Promising Practices information posted in the RISS as a tool to identify effective program integrity practices.

Appendix C: Enrollment and Expenditure Data

Table C-1 and Table C-2 below provide enrollment and expenditure data for each of the selected MCOs.

Table C-1. Summary Data for Illinois MCOs

Illinois MCO Data	BCCHP	Meridian	Molina
Beneficiary enrollment total	679,883	877,482	326,593
Provider enrollment total	38,132	54,588	41,489
Year originally contracted	2018	2008	2013
Size and composition of SIU	8.4	13	4
National/local plan	Local	Local	Both

Table C-2. Medicaid Expenditure Data for Illinois MCOs

MCOs	FY 2020	FY 2021	FY 2022
BCCHP	$3,672,839,916	$4,825,228,433	$5,334,255,703
Meridian	$4,839,494,460	$5,787,426,951	$5,947,211,351
Molina	$1,446,388,277	$2,051,239,030	$2,373,496,351
Total MCO Expenditures	$9,958,722,653	$12,663,894,414	$13,654,963,405

Appendix D: State Response

State PI Review Response Form

INSTRUCTIONS:

For each draft recommendation listed below, please indicate your agreement or disagreement by placing an "X" in the appropriate column. For any disagreements, please provide a detailed explanation and supporting documentation.

Classification	Issue Description	Agree	Disagree
Recommendation #1	To come into compliance with § 438.608(d)(1)(i), Illinois should revise the MCO general contract to include language specifying whether the MCO may retain all overpayments recovered due to fraud, waste, or abuse, or if there are extenuating circumstances wherein the state may retain overpayments.		

Acknowledged by:

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[Name], [Title]

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Date (MM/DD/YYYY)